CMS ILLINOIS DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

DEPENDENT CARE ASSISTANCE PLAN

ENROLLMENT/TRANSACTION FORM FY ___

Section A -Type of Transaction

☐ Benefits Choice Enrollment

☐ Mid-Year Enrollment/New Hire* (A change in status event has occurred that will allow the participant to Enroll in Flex outside of the normal Benefits Choice time)

☐ Change in Status Event* (A change in status event has occurred that will allow the participant to change their current Flex account i.e.: ☐ Increase/Decrease Deduction amount)

***** A Change in Status Certification must accompany this enrollment/transaction.

Section B – Employee Information

If initial enrollment, re-enrollment, or new employee, complete the entire form. If any other type of transaction, complete only the employee name, social security number and new information.

Social Security Number	*Last Name*	*First*		*Initial*
				( )
Street Address	*City*	*State*	*Zip Code*	*Home Phone*
				( )
Agency				*Work Phone*

Section C – Deduction Information and Authorization

Benefits Choice – The Number of Deductions will = 24 for Semi-monthly or Bi-weekly Pay or 12 for Monthly Pay.
– The Deduction Start Date is not required.

Outside Benefits Choice – You must work with your Group Insurance Representative to determine the Number of Deductions remaining for the year and the Deduction Start Date.

$_____ X _____ = $_____ | _____ / _____ / _____

Deduction Amt Per Pay | Number of deductions | DCAP Expenses | Deduction Start Date

I authorize the State of Illinois to deduct the above Deduction Amount Per Pay from each paycheck for DCAP.

~ OVER ~

Section D – Certification Statement (Please read carefully before signing)

I understand and certify that:

- *I may not change or stop my deposits to this account during the plan year unless I experience a qualified change in status.*
- *I will forfeit any unclaimed amount remaining in my account at the end of the run-out period.*
- *I understand that deductions must continue during any paid leave of absence and that I will not submit claims for expenses incurred during periods when I or my spouse are not actively working.*
- *I intend to participate in DCAP for the entire plan year. I do not anticipate terminating state service, retiring, or going on an unpaid leave of absence.*
- *I will refund to CMS any incorrect reimbursements or ineligible payments. If I do not repay the debt, the State may take whatever steps necessary to collect the amount owed.*
- *If my payroll deductions cease for any reason, I understand I must complete the necessary paperwork and my participation in the program will terminate on the last day of the pay period for which a deduction was taken or the last day I was actively at work, whichever is sooner.*
- *To the best of my knowledge, the information on this form is accurate. I am responsible for any discrepancies that may affect my status with the Internal Revenue Service and I will comply with the IRS requirement to file an IRS Form 2441.*
- *I understand that if either I or my spouse earns less than $5,000.00, the DCAP contribution cannot exceed the lowest income.*
- *I understand that if my spouse is a full-time student or handicapped, the DCAP contribution cannot exceed $200.00/month for one child or $400.00/month for two or more children.*
- *I understand that if I and my spouse file separate federal income tax returns, DCAP contribution cannot exceed $2500.00.*

Employee Signature: _____ **Date** ____/____/____

Return the signed, completed form to your agency Group Insurance Representative

Section E –Agency Approval *(To be completed by Group Insurance Representative)**

Organizational Processing Code: _____ _____ _____ Paycode: _____

GIR Signature: _____ Date: _____/_____/_____

Telephone ( ) _____-_____

* Upon completion of the form, forward the original to the FSA Unit at CMS. Retain one copy of the form in the member's file and give another copy to both the participant and your payroll administrator.

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